UVA Center for ASPIRE "Creating a Culture of Safety" IP PSQI Program: HRSA ANE Grant D09HP26942		
Activity Exemplar	**INTERPROFESSIONAL SIMULATION: "No Room for Error"**	**Total Time: Approx. 30 minutes** (Individual error observation-7 min; development of team error list-10 min; facilitator-led debrief 10 min.)
Instructor	**Julie Haizlip, MD, MAPP, FAPP; Clinical Professor of Nursing, UVA School of Nursing and Attending Physician in Pediatrics, UVA School of Medicine**	
Learning Objectives	▪ Identify potential safety hazards that can exist in an inpatient setting ▪ Work as an interprofessional team to identify safety concerns ▪ Learn from one another in this setting by capitalizing on one another's expertise ▪ Develop a greater sense of responsibility for patient safety	
Planning Notes	▪ Create patient scenario and identify multiple possible safety hazards specific to patient's care ▪ Obtain necessary equipment and materials for the staging of the room ▪ Create questionnaires and evaluations ▪ Pilot the activity, review the process, seek feedback from pilot participants, and revise as necessary ▪ Schedule activity to allow maximal participation from different disciplines	
Session Materials	▪ Simulation space and equipment (e.g., mannequin, hospital bed, bedside table, sharps container, IV pump) ▪ Printed materials (e.g., Facilitator script, sample list of errors, blank individual and team error lists, post-activity survey). For more information on these materials, please send a written request to ***aspire@virginia.edu*** ▪ Other materials (e.g., Facilitator timer, participant clipboards and pens)	
Student Comments	*"This definitely opened my eyes to what different members of the care team identify as errors. It makes it evident how important a multidisciplinary approach is to patient safety."* *"This activity was awesome! I loved collaborating at the end so all the errors were brought to light…So many I didn't notice."*	
Lessons Learned	▪ Limit size of the group so participants have space to move around while observing errors ▪ When creating scenario, include errors of omission ▪ Consider interprofessional facilitation of group debrief ▪ In group debrief, let students drive the conversation	